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A good death for the oldest old

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People aged over 85 years are the fastest growing segment of the population, both in the UK and across all high-income countries. This is also the group of people who are most likely to die. So it is pertinent to consider how we can ensure that for the oldest old, their deaths, as well as their lives, are as good as we can help them to be.

The linked paper by Pocock and colleagues[1] gives a valuable snapshot of where deaths occur in the UK for the oldest old. The results, based on a large, representative sample of UK deaths in those aged 85 and over, show that the majority of the oldest old die in hospital. Frail older people who had been resident in care homes, those with dementia or cancer and those aged over 95 years were less likely to die in hospital; however those from deprived postcodes, those with more severe comorbidities, and those with multiple hospitalisations in the previous year were more likely to die in hospital. Due to the large-scale nature of the data sources used, some key variables could not be incorporated in the analyses – in particular, we do not know the preferred place of death for individuals or what type of hospital death occurred. Also, we are unable to ascertain what their symptom burden or care needs were at the end of life, and the data are dependent on the quality of coding from death certificates; such data may not capture either the cause of death with full accuracy, nor does it capture the multiple contributory causes of death experienced by most older people.

The results give us pause to consider successes, failures and challenges in the way that we care for the oldest and frailest at the end of their lives. Whilst it is wrong to view death in hospital as a failure of end-of-life care, it is clear that the percentage of people dying in hospital is much higher than the number of people who state a preference for hospital as their preferred place of death [2]. However, the higher proportion of deaths outside hospital for people with both cancer and dementia suggests that at least for these groups of patients, care planning and service delivery are able to support death outside the hospital environment.

This still leaves a large number of very old people who are dying in hospital – a group likely to include many people dying of either acute intercurrent illness (e.g. pneumonia as noted in the current study) as well as large numbers with cardiovascular and other respiratory causes of death. Illness trajectories for these conditions are more difficult to predict, often following a relapsing-remitting course [3], and as a result, physicians may be reluctant to diagnose dying. This is a particular issue for infections, which are often viewed (by both clinicians and relatives) as curable; this may of course be the case for an individual bout of infection, but in the very frail and old, pneumonia may indeed be the 'old man's friend'; the end of the dying process, rather than an isolated acute illness. Illnesses with a relapsing-remitting course are likely to lead to multiple hospitalisations, which may partly explain the associations seen in the current study.

So how can we improve matters, and what lessons can we derive from this work? The first key point lies in diagnosing that the end of life is approaching. The fact that multiple hospitalisations are associated with an increased risk of dying in hospital – as reported in the current study – reinforces that multiple hospitalisations are a risk marker for the approach of death, and also perhaps highlights missed opportunities to identify the approach of death during hospitalisation. Tools exist to help characterise this risk (both disease-specific, e.g. in heart failure[4], and generic[5]), but clinicians may require training and support to feel confident in moving from a curative, episode-based model of hospital care to that of palliative care where the focal point becomes good symptom control and quality of life with attention on the person and their family rather than the disease[6]. Part of this shift in focus also needs to be in viewing death and dying as a process that occurs over weeks to months, not just the few days prior to death.

Secondly, if patients are to be supported to die well outside hospital, sufficient resources and expertise need to be available in the community to facilitate this. Responding to crises requires rapid

mobilisation of personnel and skills if the default pathway of hospital admission is to be avoided. Whilst primary care needs to be the main provider of such services, both specialist palliative care teams and geriatricians have a supporting role to play here, alongside others with relevant expertise (e.g. heart failure specialist nurses). Such community-facing interdisciplinary teams can deliver for the cancer trajectory; the challenge is to ensure that they can deliver for non-cancer trajectories of dying as well, especially in frail older people. The good news here is that as geriatricians re-engage with primary care via locality working and community geriatrics, such interdisciplinary team working is likely to become stronger. However, more may be needed, and local centres of excellence (e.g. step-down / step-up beds with geriatricians and others experienced in palliative care) could help to model and disseminate innovative practice, as well as providing an alternative to acute hospital admission for complex care needs or issues of symptoms control.

Thirdly, we need more conversations about death and dying. Whilst this risks becoming a trope, older people and their families cannot make choices about dying without such conversations. The use of anticipatory care planning, particularly in care homes, is now becoming established, and use of such tools can help to ensure that those in care homes die where they want to – whether that be in the care home or in hospital. We now need to recommit to having these conversations with frail older people being re-admitted to hospital – even though in the case of acute intercurrent illness or relapsing-remitting illness, such conversations may be more uncertain and more difficult.

Finally, we need to ensure that care at the end of life in hospital is as good as it can be. Care of the dying and the palliative care needs of the dwindling trajectory is core business for geriatricians, and we need to ensure that in the race to establish acute services, to move people through hospital systems quickly, to liaise with surgical services and to offer geriatrician time and expertise to other specialities across the hospital, we do not lose sight of our responsibilities to provide the best care possible for our oldest patients dying in hospital. Fortunately, the growing role of geriatricians

working at the hospital front door, with early, senior assessment[7], working across the hospital/community boundary could (if managed well) be part of the solution; interface geriatrics teams are well positioned to identify those older people who are likely to die, and to ensure that they are helped to die in both the right place and the best way possible.

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